Michigan Department of Community Health
Mental Health and Substance Abuse Administration

PROGRAM POLICY GUIDELINES FOR COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

February 1, 2009

Michigan Department Of Community Health

MDCH

FY 2009 PROGRAM POLICY GUIDELINES FOR CMHSPS

Final: February 1, 2009

The foundation for partnerships and the goal for community membership for all individuals who require services and supports from the public mental health system are embedded in the Michigan Mental Health Code (Code), Public Act 258 of 1974 as amended. The roles and responsibilities of the state and counties are outlined. The Code requirement for a community, stakeholder and consumer "voice" is the keystone for planning and allocation of resources. Annually, each CMHSP must examine and evaluate the mental health needs of the county or counties it serves and submit both a plan and a budget for the program. Each year, MDCH issues the program policy guidelines (PPGs) and related guidance containing the requirements and instructions to satisfy Code and legislative reporting requirements and to provide statewide policy direction.

This past August, MDCH issued its Concept Paper on "Focusing a Partnership for Renewal and Recommitment to Quality and Community in the Michigan Public Mental Health System" that provided an overall vision for policy direction in the coming years. As stated in the Concept Paper, it was the intent of MDCH that the subsequent PPGs for CMHSPs, and the Application for Renewal and Recommitment (ARR) for pre-paid inpatient health plans (PIHPs) would serve as the vehicles to receive baseline data and information, and FY09 or FY10 plans on how those public mental health agencies would implement the vision articulated in the Paper. The data, information and plans generated in responding to the PPGs will need to be used by the PIHPs in their ARR environmental scans, and the development and implementation of their PIHP-wide plans for improvement.

These PPGs do not address all topic areas in the Concept Paper and ARR, but instead focus on five areas that MDCH believes are critical in improving CMHSP supports and services. The sections of the ARR to which each area is relevant are in the parentheses that follow. The PPG topic areas are:

- Building a system of care for children with serious emotional disturbance (ARR Sections 2, 6, 7 and 8)
- Building a system of care for children with developmental disabilities (ARR Sections 2, 6, 7 and 8)
- Improving outcomes for people with developmental disabilities (ARR Sections 3, 7 and 8)
- Implementing the Recovery Enhancing Environment Measure for adults with serious mental illness (ARR Section 2)
- Enhancing access to, and improving the implementation of, self-determination arrangements (ARR Section 4)

Each of the five sections of the PPGs has somewhat different instructions. For example, improving outcomes for people with developmental disabilities requests that baseline data be submitted to MDCH, and to the PIHP if the CMHSP is an affiliate, and that the any plans for improvement not be submitted to MDCH, but instead be used by the PIHP

to develop its ARR quality improvement plan. The System of Care for Children (either with SED or DD) requests information be submitted to MDCH on each CMHSP's planning process. The section on the Recovery Enhancing Environment Measure expects that the CMHSP will submit to MDCH a description of its plan for administering the measure.

Following the instructions for the five sections, CMHSPs must electronically submit the required data, information and plans by 5:00 p.m. March 16, 2009 to DCH-ARR-PPG-Responses@michigan.gov at MDCH, and if the CMHSP is an affiliate, to the appropriate liaison at its PIHP. Please use the 2009 PPG Data Table files for submission of each section of the PPG's information to MDCH, and clearly identify the CMHSP and a contact person on the first page of each document.

SYSTEM OF CARE FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

Problem Statement:

To improve outcomes for children with serious emotional disturbance (SED), birth to 18 years of age and their families, the development of a community system of care is encouraged. The system of care is to be comprehensive, family-centered, community-based, and culturally and linguistically competent. It is a *system that is developed for children/youth and their families that represents the organization of public and private services within the community into a comprehensive and interconnected network in order to accomplish better outcomes for children.*

The anticipated outcomes for children and their families in a system of care at the systems level and child and family level are described below. They include:

At the system level:

- Development and maintenance of a comprehensive array of mental health services and supports for children and their families.
- Improved access to mental health services that are responsive to the needs identified by children/youth and their parents.
- Services are provided where children and their families live and in natural settings (home, school, community, etc.).
- Blended resources among child-serving providers increase total dollars available for mental health services.

At the child and family level:

- Children improve in their functioning and behavioral concerns are reduced.
- Children improve in their school attendance and grade achievement.
- Children have fewer contacts with law enforcement and, if previously involved with juvenile justice, have few subsequent contacts with that system.
- Children have permanency and there is reduction in the abuse and neglect of children.
- Parents of children serviced in systems of care experience reduced strain associated with care for children with a serious emotional disturbance, improved adequacy of resources for their families, and improvement in overall family functioning.

System of Care:

Communities were requested to utilize a system of care planning process in preparation for application for funding from the Children's Mental Health Block Grant (FY 07, 08 and 09) and/or in implementing the 1915(C) SED Waiver. MDCH is particularly interested **in increasing overall access to specialty mental health services and supports for Medicaid-eligible children/youth with SED and specifically children in Child Welfare** (i.e., abuse/neglect and/or adopted children/youth) **and Juvenile Justice.** Although not all children served by the CMHSP are covered by Medicaid, a significant proportion are Medicaid and, therefore, in FY08 and continued in FY09 the Medicaid capitation for children, both with developmental disabilities (DD) and SED, was

increased and performance targets for each PIHP and its affiliate members for increased access to specialty mental health services were included as an attachment to the FY09 DCH/PIHP contract. This system of care planning process would address needs of children served by Medicaid, General Fund, MIChild, and Children's Mental Health Block Grant funding.

In implementation of a system of care planning process, CMHSP and local stakeholders were asked to identify all of the mental health services for children/youth and their families available in the community. In addition to the identification of those services being provided, communities were requested to identify who is providing the service, the number of children/youth served in the past year, total cost and funding source(s). The information is to be provided by all relevant stakeholders (CMHSP, Child Welfare, local/regional Educational Services Agency(ies), Juvenile Court and/or other providers of mental health services to children and their families in the community) to assist with the discussion of current array available, the identified needs for service enhancement/improvement and identification of potential strategies to improve the array of mental health services and supports in the community for children/youth who have SED and their families.

In order to account for the work that has been done in the local community to plan for and/or develop the system of care for all children with SED, the CMHSP is expected to share, in the attached SED Table #1, the status of its local planning process for the development of a system of care including responding to the needs of children with SED served in child welfare and/or juvenile justice. Below are questions to use in the planning process.

1. What does the current system of care planning consist of, including identification of stakeholders, committee structure, and meeting dates?

2. What services, supports or processes have been identified as needed to improve public mental health component of the system of care for children/youth (0-3, 4-7, 7-17 years of age) and their families by CMHSP and their community stakeholders (including parents/youth)?

- Development of a new service?
- Improving a current service?
- Building the capacity of the current services?
- Developing an evidence based/promising practice?
- Ensuring access to mental health services for children/youth with SED (i.e. through screening and assessment)?
- Braided/blended funding?
- Other services or supports?

3. Of the need identified, what are the priorities for implementation in the community? What is the CMHSP's role in the implementation of the priority (ies)? What are the other stakeholders' roles? Do the priorities include the implementation of evidence-based and/or promising practices?

4. What are CMHSP and their community partners doing to improve parent and youth involvement in the system of care development?

Children with Serious Emotional Disturbance
System of Care Development Work Plan

Please complete and submit the two tables below to MDCH.

SED Table #1

Activity	Leadership	Date Completed
1.The current system of care planning consists of, including identification of stakeholders, committee structure, and meeting dates.	CMHSP Leadership (Participants: _____)	
2. Services, supports or processes have been identified that are needed to improve the public mental health component of the system of care for children/youth (0-3, 4-7, 7-17 years of age) and their families by CMHSP and their community stakeholders (including parents/youth).	CMHSP Leadership (Name: _____)	
3. Of the needs identified, priorities for implementation in the community have been established. The CMHSP's role in the implementation of the priority (ies) had been defined. Other stakeholders' roles have been defined. The priorities include the implementation of evidence-based and/or promising practices.	CMHSP Leadership (Name: _____) and Stakeholders	
4. CMHSP and their community partners have taken action to improve parent and youth involvement in the system of care development.	CMHSP Leadership (Name: _____) and Stakeholders	

In SED Table #2, identify any community partners with whom the CMHSP is having difficulty in communicating or coordinating in these planning activities. For those listed as "yes," indicate the kind of assistance that is needed to resolve the problems.

SED Table #2

Community Partner	Yes No	Assistance Needed
Child Welfare (Department of Human Services)		
Special Education Provider (ISD, RESA and/or LESA) or Major School System		
Courts/Juvenile Justice		
Early On		
Other stakeholders		

SYSTEM OF SERVICES AND SUPPORTS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

Problem Statement:

Increasingly, we understand that, as with all children, the foundation for good outcomes for children with developmental disabilities (DD), birth to 18 years of age, is linked to their opportunity to grow and develop within the context of consistent and nurturing relationships of their family. In keeping with this understanding, MDCH policies and funding mechanisms have shifted support away from out-of-home placements in foster care, group homes, and institutions and toward supporting children in their home and in their community. Therefore, to improve outcomes for children with DD and their families, the development of a community system of care is encouraged which promotes a culture of gentleness.

While policies and funding have shifted to support children with DD residing in their home and community, there continues to be barriers to permanence and community inclusion for some children with DD that include:

- Lack of early identification of infants and young children with DD and coordination of services with *Early On.*®
- Lack of services and supports to assist children with DD who have problem behaviors, most notably aggressive behaviors, to ensure stability in the home and community.
- Lack of access to the intensity of service needed to sustain the child in their home and community, and lack of access to best practice approaches and/or evidence-based practice to the extent they exist for certain disabilities.
- Lack of access to medically necessary services such as comprehensive assessments (including functional assessment of behavior), habilitative services, and family support services.
- Lack of coordination between mental health, education, child welfare, juvenile justice and other service/supports providers in the community.

To address the identified barriers and to improve outcomes for children with DD and their families, the development of a system of services and supports is recommended. The CMHSP shall provide leadership in the development of a system of services and supports, including the convening of community stakeholders (services and supports providers) and parents/youth.

System of Services and Supports:

The system of services and supports is to be comprehensive, family-centered, community-based, culturally and linguistically competent. It is a *system that is developed for children with DD and their families, and represents the organization of public and private services within the community into a comprehensive and interconnected network in order to accomplish better outcomes for children.*

The anticipated outcomes for children and their families in a system of care at the systems level and child and family level are described below. They include:

At the system level:

- **Development and maintenance of a comprehensive array of mental health services and supports for children and their families.**
- **Improved access to mental health services that are responsive to the needs identified by children/youth and their parents.**
- **Services are provided where children and their families live and in natural settings (home, school, community, etc.)**
- **Blended resources among child-serving providers increase total dollars available for mental health services.**

At the child and family level:

- **Children improve in their functioning and behavioral concerns are reduced.**
- **Children improve in their school attendance and grade achievement**
- **Children have fewer contacts with law enforcement and, if previously involved with juvenile justice, have few subsequent contacts with that system.**
- **Children have permanency and there is reduction in the abuse and neglect of children**
- **Parents of children serviced in systems of care experience reduced strain associated with care for children with a serious emotional disturbance, improved adequacy of resources for their families, and improvement in overall family functioning.**

In order to account for the work that has been done in the local community to plan for and/or develop the system of care for all children with DD, the CMHSP is expected to share, in the attached DDC Table #1, the status of its local planning process for the development of a system of care including responding to the needs of children with DD served in child welfare and/or juvenile justice. Below are issues to address in the planning process.

The MDCH Office of Mental Health Services to Children and Families will provide technical assistance to assist the CMHSP in the system of services and supports planning process. Specific information on technical assistance will be sent to the CMHSP Executive Director at a later date.

Planning Process:

1. In a system of services and supports planning process, the CMHSP, along with community stakeholders and parents/youth, begin the process with an identification of:
   - Services and supports available in the community for children/youth with DD and their families.
   - Who is providing the service, the number of children/youth served in FY08, the capacity of the program/agency, total cost and funding source(s). The information is to be provided by all relevant stakeholders (CMHSP, Child

Welfare, Juvenile Court and/or other providers of mental health services to children with DD and their families in the community).
- Supports available to children with DD in the community (i.e., local recreational opportunities, faith-based activities/opportunities, etc.).

2. With the identification of services and supports available in the community for children with DD and their families, the CMHSP, parent/youth and the stakeholders identify strategies to improve access to CMHSP services for children that are served in other systems (Child Welfare, Juvenile Justice/Courts, Educational Services Agency (ies), *Early On*, etc.).

   In the system of services and supports planning process of the community stakeholders and parents/youth, the discussion of the availability of services and supports, along with access issues, is to be coupled with an exploration of the effectiveness of the current service array. Is the service array provided by CMHSP effective? Does it result in improved outcomes for children with DD, especially those children who exhibit aggressive and/or problematic behaviors at home or in the community?

3. What service, supports or process has been identified as needed to improve the public mental health component of the system of services and supports for children/youth with developmental disabilities (0-3, 4-7, 7-17 years of age) and their families by CMHSP and their community stakeholders (including parents/youth)?

   What is the need?
   - Development of a new service?
   - Improving a current service?
     - Building the capacity of the current services?
     - Developing an evidence-based/promising practice?
     - Ensuring access to mental health services for children/youth with DD (i.e. through screening and assessment)?
     - Blended/braided funding?
     - Other services or supports?

4. With the identification of the need, the stakeholders are asked to identify their priorities for action planning. What is the CMHSP's role in the implementation of the priority (ies)? What are the other stakeholders' roles? Do the priorities include the implementation of an evidence-based practice and/or promising practice?

Upon determination by the stakeholders of the priorities, the next step in the planning process is to develop the action plan to address the priorities.

5. In the process to develop/improve a system of services and supports for children with DD, involvement by parents of children with DD and youth with DD is optimal. Their involvement in the system of services and supports planning process (system level),

as well as at the child/family level, will assist in improving outcomes for children and families.
What are the CMHSP and their community partners doing to improve parent and youth involvement in the system of care development?
What is being done to improve parent and youth involvement in service level planning and implementation of individualized plans?

6. In addition, a discussion to further the understanding between the stakeholders and CMHSP of how to ensure the coordination of services for children with DD with schools, services/supports providers and the family needs to be held.

Children with Developmental Disabilities
System of Services and Supports Development Work Plan

Please complete and submit the two tables below to MDCH.

DDC Table #1

Activity	Leadership	Date to be Completed
1. CMHSP will participate in Technical Assistance Session on System of Care (provided by MDCH).	CMHSP Leadership (Participants: _____)	Early 2009 Date to be determined
2. CMHSP identifies stakeholders to participate in the system of care planning. a. Identifies stakeholders from Educational Services Agency (ies), Child Welfare/DHS, *Early On*, Juvenile Justice/Courts, other public/private agencies, parents and youth. b. Works with Community Collaborative regarding identification of stakeholders.	CMHSP Leadership (Name: _____)	
3. Stakeholders identify all of the mental health services (formal) and supports (informal) available to children with DD and their families. a. Stakeholders identify who is providing the service, the number of children/youth served in FY08, the capacity of the program/agency, total cost and funding source(s). b. Stakeholders identify supports available to children with DD in the community (i.e., local recreational opportunities, faith-based activities/opportunities, etc.).	CMHSP Leadership (Name: _____) and Stakeholders	
4. Stakeholders identify strategies to improve access to CMHSP services for children that are served in other systems (Child Welfare, Juvenile Justice/Courts, Educational Services Agency (ies), *Early On*, etc.).	CMHSP Leadership (Name: _____) and Stakeholders	
5. What are the services, supports, processes identified to improve the system of services and supports?	CMHSP Leadership (Name: _____)	
6. Of the needs identified, what are the priorities for implementation in the community? a. What is CMHSP's role in the implementation of the priority (ies)? b. What are the other stakeholders' roles? c. Do the priorities include the implementation of an evidence-based practice and/or promising practice?	CMHSP Leadership (Name: _____)	

7. What are CMHSP and their community partners doing to improve parent and youth involvement in the system of care development? What is being done to improve parent and youth involvement in service level planning and implementation of individualized plans?	CMHSP Leadership (Name: _____)	
8. Does the CMHSP have interagency agreements that clearly define roles and responsibilities, as well as lines of accountability, with: a. Child Welfare (Department of Human Services) b. Special Education Provider (ISD/RESA and/or LESA) c. Court/Juvenile Justice d. *Early On* e. Other stakeholders/partners in the provision of services to children with DD and their parents.		

In DDC Table #2, identify any community partners with whom the CMHSP is having difficulty in communicating or coordinating in these planning activities. For those listed as "yes," indicate the kind of assistance that is needed to resolve the problems.

DDC Table #2

Community Partner	Yes No	Assistance Needed
Child Welfare (Department of Human Services)		
Special Education Provider (ISD, RESA and/or LESA) or Major School System		
Courts/Juvenile Justice		
Early On		
Other stakeholders		

IMPROVING OUTCOMES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Problem Statement:

Success has been seen in Michigan, and across the nation, when people with developmental disabilities are provided the right supports in the right place: they can live with a minimum of supervision and structure; they can travel the community and participate in activities there; and they can earn a wage. Given this success, MDCH has used various policies and Medicaid and non-Medicaid funding mechanisms to encourage the public mental health system to develop and offer options that help people live the life they want in the community. For example, the approval of the 2003 1915(b) Medicaid waiver renewal application resulted in Michigan being able to offer a flexible set of Medicaid supports and services, that are in addition to the Medicaid state plan services, under the authority of Social Security Act Section 1915(b)(3). The intent of these "b3" supports and services was to help individuals with serious mental illness and developmental disabilities achieve their goals of community inclusion and participation, independence and productivity.

While polices and funding have removed some of the barriers to helping individuals live, work and socialize in the community, there remain other barriers to achieving these successes, as well as risks to their current situation (e.g., home, job). These have been identified as:

- Lack of resources to address problem behaviors
- Disability or death of a family caregiver
- Lack of daily activities

These problems have resulted in people with developmental disabilities being placed in nursing homes, state and private facilities, or restrictive group homes. Some have lost their jobs or their "slots" in sheltered workshops, or have been expelled from school. Some adults and youth with developmental disabilities have been arrested and jailed. Some have experienced aversive techniques or chemical restraints to control their behavior, while others have received only custodial care with no therapies that might have improved their physical conditions. Some individuals spend most of their days at home (group home, own home, family home) because the CMHSP has not facilitated access to a rich variety of activities outside the home in which adults might choose to participate. They include, but are not limited to, work, volunteering, recreation, socialization, classes, and specialty supports. These issues are viewed by CMHSPs, providers or parents/guardians as reasons to prevent many other people with developmental disabilities from pursuing their goals of lives in the community.

While MDCH does not forbid the use of public mental health dollars, including the 1915(b)(3) supports and services, to be used in traditional settings (group homes, day programs, and sheltered workshops), there is renewed expectation that the public mental health system will become more proactive in providing opportunities for, and information about, true community inclusion and participation, independence and productivity. The CMHSP will develop FY2010 plans, as instructed in the following

pages and supported by the data in the accompanying tables, for how it will address the needs of people who exhibit problem behaviors; for assisting people to make transitions from family care giving and school; how the adults with developmental disabilities being served will be helped to become more actively engaged in life; and how it will begin moving adults from large congregate settings, and children from any congregate setting to more natural homes in the community.

CMHSPs will submit the tables one through four to MDCH. CMHSPs that are also PIHPs will use the plans described herein for developing their responses to the Application for Renewal and Recommitment (ARR). CMHSPs that are affiliate members of PIHPs should submit their plans to their PIHPs to be used in the development of the responses to the ARR.

CMHSP DATA COLLECTION AND PLANS FOR FY 2009: IMPROVING OUTCOMES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Note: Please use attached tables to enter data resulting from the analyses requested below. Unless otherwise noted, use the entire FY08 as the bases of analyses. Development of plans should focus on FY09.

1. **Addressing the Needs of People with Developmental Disabilities who Exhibit Problem Behaviors**

   a. The CMHSP will conduct an analysis of adults and children with developmental disabilities, including those with co-occurring serious mental illness or emotional disturbance, served to determine who in FY 2008 had a behavior treatment plan or when a plan did not exist, experiences an emergency behavioral intervention that use aversive, intrusive, or restrictive techniques or physical management or restraint for behavior control purposes[1]. The analysis will also include who from this population was moved in FY 2008 from one residence to another (including to a state or private facility), or ended their day time activity (employment, workshop, recreation) because the staff or the setting lacked the capacity to appropriately address a problem behavior. Further, the analysis will address adults and children with developmental disabilities served by the CMHSP in FY 2008 who could not return from a state or private facility because capacity and resources (e.g., appropriate setting, supports, staffing to address a problem behavior were not available locally. Finally, the analysis will address adults and youth with developmental disabilities served by the CMHSP in FY 2008 who were arrested, booked, jailed or convicted because of a problem behavior.

In Table 1, rows a.i. through a.vi., enter the unduplicated number of adults and children in separate columns who were found in FY08 to experience i) behavior treatment plans, ii) emergency interventions, iii) residential movement because of behaviors, iv) suspension from activities, v) restriction of movement from a state or private facility because of behaviors, and vi) arrest, booking, incarceration or conviction because of behaviors.

   b. The CMHSP will identity adults and children with developmental disabilities, served in FY 2008, who were prescribed any medications to be used for behavior control, whether on a continuous basis or PRN and whether there were behavior treatment plans dictating the use of these medications. The analyses should include whether the individuals receiving these medications had an additional diagnosis of mental illness; all the medications used and how many individuals received them for the purpose of behavior control; and whether medication monitoring plans were in place.

In Table 1, rows b.i and b.ii, enter the number of adults and children in separate columns who were found in FY08 to i) have received medications for the purpose of behavior control and ii) have medication monitoring plans.

[1] For definition of these techniques, please refer to The Technical Requirement for Behavior Treatment Plan Review Committees, Attachment 1.4.1 of the MDCH/PIHP and CMHSP FY09Speciality Services and Supports Contracts

DD Table #1

	Improving Outcomes: Addressing Behavior Problems	Number of Unduplicated Adults with DD Served in FY08	Number of Unduplicated Children with DD Served in FY08
1.a.i	A behavior treatment plan was in place sometime during the year		
1.a.ii	An emergency intervention using aversive, intrusive or physical management techniques for behavior control, that was not part of a treatment plan, was used during the year		
1.a.iii	Individuals were moved from one residence to another because of problem behavior(s)		
1.a.iv.	Individuals were suspended from an activity (including school, work, program) because of problem behavior(s)		
1.a.v...	Individuals could not return to the community from a state or private facility because of problem behavior(s)		
1.a.vi.	Individuals were arrested, booked, jailed or convicted because of problem behavior(s)		
1.b.i	Individuals who received medications for behavior control during the year		
1.b.ii	Of the individuals identified in 1.b.i, how many had a medication monitoring plan?		
		Total Adults with DD served in FY'08: ###	Total Children with DD served in FY'08: ###

c. Develop a plan for providing the necessary resources (staffing, training, alternative housing and other supports) to accommodate people with developmental disabilities who exhibit or are at risk of exhibiting problem behaviors. Describe the kinds of situations or behaviors for which the CMHSP has sufficient, or even expert, capacity (expertise, resources, etc.) to assist individuals. Identify by name the expertise or resources that will be used. Describe any training and mentoring that will be provided to staff on positive behavioral supports. Identify the training and mentoring by name of author or presenter. The plan should also describe the kinds of situations or behaviors for which the CMHSP lacks sufficient capacity to make the necessary accommodations for individuals who exhibit problem behaviors; and identify the expertise or resources that the CMHSP needs.

2. <u>Transitioning from Family Care-giving and School Life</u>

a. As part of its needs assessment process, the CMHSP will identify the number of adults with developmental disabilities served and un-served in its catchment area who are currently (FY09) living with natural or adoptive family who provide their care full- or part-time. Of those, the CMHSP will determine who have caregivers who are aging or disabled and will soon (within the next one to five years) be unable to provide full-time or part-time care. In addition, the CMHSP will ascertain who of the adults living with family caregivers, have expressed the desire to live more independently.

In Table 2, rows a.i through a.iv., enter the number of adults served and un-served who were found to be living with natural or adoptive family caregivers; the number of those adults (identified in a.i.) whose family caregivers will be unable to provide care within one year and five years, and the number of adults (identified in a.1.) who have requested independent or support independent living.

b. The CMHSP's needs assessment should also focus on students (aged 16 to 26) with developmental disabilities who are currently (FY09) in school, including regular education and special education programs, whose transition plans call for them to go to the CMHSP for comprehensive adult services following graduation. The CMHSP should evaluate how many individuals in the next one to five years will seek adult services, and the kinds of services they will require (e.g., case management/supports coordination, skill building, supported employment, and/or community living supports in family home, independent living or group home).

In Table #2, rows b.i through b.iii., enter the number of students aged 16 or more, served and un-served by the CMHSP, who have a school transition plan that identifies their receiving services from the CMHSP when they exit education or graduate; the number who have plans who will graduate within one year; and the number who have plans who will graduate within five years.

DD Table #2

	Improving Outcomes: Transitioning from Family Care-giving and School Life	**Number of Unduplicated Adults with DD in FY09***	**Number of Unduplicated Students with DD in FY09***
2.a.i	Adults living with family caregivers		
2.a.ii	Adults whose family caregivers will be unable to provide care within one year		
2.a.iii	Adults whose family caregivers will be unable to provide care within five years		
2.a.iv	Adults living with family who have requested an independent or supported independent living arrangement		
2.b.i	Students aged 16 or more who have a school transition plan		
2.b.ii	Students who will exit education or graduate within one year		
2.b.iii	Students who will exit education or graduate within five years		

*Number should include individuals currently (FY09) served and individuals not yet served but identified in the catchment area as needing services in the future

c. Develop a plan for FY2009 for assisting adults with developmental disabilities identified above to receive the necessary supports in their family home whose caregivers are likely to become less able or unable to provide care in the next one to five years; and to assist individuals who will need or want to move from their family home find a place of their choosing in which to live, with the necessary supports in the next one to five years. Identify the existing expertise and resources the CMHSP will utilize and any additional expertise or resources that will be needed locally to assist the family care-givers, and those adults with developmental disabilities who want or need to leave their family home and find

an appropriate place to live. The CMHSP plan will also address how it will meet the demands of students exiting or graduating from public school in the next one to five years, and identify the expertise and resources it will use, and the expertise and resources that it needs.

3. **Adults Engage in Meaningful Activities of Their Choice** such as classes, volunteering, socializing with friends and relatives, and recreating outside the home. Integrated employment, supported employment, skill-building in the community, work and skill-building in a work activity program, and performing personal errands (such as shopping, voting, banking), outside their home homes. For purpose of this analysis "activities" exclude clinical services, medical appointments, transportation, or accompanying staff on their errands.
   a. The CMHSP will analyze for each adult with developmental disabilities being served the kinds (see above), numbers, and scope (approximate hours per day and days per week) of activities that they chose and participated in, outside their home in a week.

In Table #3, enter in row "a" the number of adults served in FY08, who usually do not participate in any activity of their choice outside their homes in a week during the year. Count here any adult who participated in one activity of his/her choice in 25 or fewer weeks a year. In row b, enter the number of adults served who had between two and four *different* activities of their choice in a week. If an individual works three days a week, count as that as one activity. In row c, enter the number of adults served who had five or more *different* activities of their choice in a week. If an individual works three days a week, and visits his parents once a week, count those as two activities.

DD Table #3

	Improving Outcomes: Adults Engaged in Meaningful Activities	**Number of Unduplicated Adults with DD Served in FY08**
3.a.	Usually (less than 26 weeks of the year) do not have activities* of their choice outside their homes each week	
3.b.	Have an average of one activity* of their choice outside their homes per week	
3.c.	Have between an average of two and four *different* activities* of their choice outside their homes per week	
3.d.	Have an average of five or more *different* activities* of their choice outside their homes per week	
		Total unduplicated cases of adults with DD served in FY'08: ###

*Activities are individual-chosen classes, work, volunteering, socializing, recreating or specialty supports (e.g., skill-building) outside the home; excludes medical appointments (MD, DO, PA, RN, DDS, OT. PT, or Lab) and transportation.

b. Develop a plan for how the CMHSP will assist adults with developmental disabilities to choose an <u>increased</u> number and variety of activities outside their homes and how the CMHSP will provide, or make available, the supports needed to engage in those activities in FY09. The plan should address how the adults and any guardians who make decisions on their behalf, will be assisted to learn about activities and, if necessary, be given the opportunity to try the activities before choosing them for their plans of service. Individuals should not be forced to participate in activities they do not like or more often than they prefer. Include the expertise or resources the CMHSP will use in order to accomplish that. Identify any expertise or resources the CMHSP will need in order to make available an increased number and variety of activities outside their homes for adults with developmental disabilities who choose more.

4. **<u>Adults and Children Live in the Least Restrictive Environment</u>** in their home communities with or near natural family, and other supporters (friends and advocates), and are offered opportunities to experience, then choose if desired, supported independent living.

a. The CMHSP will ascertain the adults with developmental disabilities for whom the CMHSP paid for care in FY08, in licensed private or public facilities in county or out-of-county including out-of-state, where more than six people with developmental or other disabilities live. The analysis will include the reasons for admission, the length of stay, what attempts have been made to discharge from the facilities, and the outcomes of the attempts.

In Table #4a, enter the name, street address, city and zip code of all facilities that are licensed for more than six beds where individuals with developmental disabilities reside for whom the CMHSP is paying for the care. In the next five columns enter for <u>each facility:</u> i) the licensed bed capacity; ii) the number of adults with developmental disabilities who reside there (for whom the CMHSP is paying for care); iii) the number of them who have a transition plan as of 10/1/08; iv) the average cost per day the CMHSP is paying; and v) the average length of stay by number of months (may exceed 12 months).

DD Table #4.a

Name, street address, city and zip code of residential facility* licensed for more than 6 beds [Add rows as needed]	Licensed bed capacity	# of Adults with DD for whom CMHSP paid care in FY08**	# Who have a transition plan as of 10/1/08	Average cost paid by CMHSP per day in FY08	Total average length of stay - # of months up to 10/1/08

Name, street address, city and zip code of residential facility* licensed for more than 6 beds [Add rows as needed]	Licensed bed capacity	# of Adults with DD for whom CMHSP paid care in FY08**	# Who have a transition plan as of 10/1/08	Average cost paid by CMHSP per day in FY08	Total average length of stay - # of months up to 10/1/08

*Facility= nursing care facility, congregate care facility, boarding school, child caring institution, licensed foster care setting with bed capacity of 7-12, 13- 20 and 20+
** Both within and outside the CMHSP's catchment area

c. The CMHSP will ascertain the children with developmental disabilities up to age 18 for whom the CMHSP paid for care in FY08, in any licensed private or public facilities in-county or out-of-county including out-of-state, regardless of size. The analysis will include the reasons for admission, the length of stay, what attempts have been made to discharge from the facilities, and the outcomes of the attempts.

In Table #4b, enter the name, street address, city and zip code of all residential facilities that are licensed for children where children with developmental disabilities reside for whom the CMHSP is paying for care. In the next five columns enter for <u>each facility</u>: i) the licensed bed capacity; ii) the number children with developmental disabilities who reside there (for whom the CMHSP is paying for the care); iii) the number who have a transition or permanency plan as of 10/1/08; the average cost per day the CMHSP is paying; and the average length of stay in number by numbers of months (may exceed 12 months).

DD Table #4.b

4.b. Name, street address, city and zip code of residential facility* licensed for children [Add rows as needed]	Licensed bed capacity	# of Children with DD for whom CMHSP paid care in FY08	# Who have a transition or permanency plan as of 10/1/08	Average cost paid by CMHSP per day in FY08	Average length of stay - # of months up to 10/1/08

4.b. Name, street address, city and zip code of residential facility* licensed for children [Add rows as needed]	Licensed bed capacity	# of Children with DD for whom CMHSP paid care in FY08	# Who have a transition or permanency plan as of 10/1/08	Average cost paid by CMHSP per day in FY08	Average length of stay - # of months up to 10/1/08

*Facility= nursing care facility, congregate care facility, boarding school, child caring institution, licensed foster care setting with bed capacity of 1-6, 7-12, 13- 20 and 20+
** Both within and outside the CMHSP's catchment area

c. Develop a plan for how the CMHSP will find permanent smaller settings for adults that include supported independent living for those who prefer it. Identify the number of adults who will be targeted for moving in FY10. For children living in congregate care of any size, provide a plan for how the CMHSP will return them to their natural or adoptive families with appropriate supports or find alternative family settings. Identify the number of children who will be targeted for moving in FY09. The plan will describe the expertise or resources the CMHSP has that will be used in this activity, and the expertise or resources the CMHSP will need.

RECOVERY ENHANCING ENVIRONMENT MEASURE

Background:
The Recovery Council, in partnership with MDCH recommended implementation of the Recovery Enhancing Environment Measure[2] (REE) within each CMHSP and within each contract/provider agency during FY09. The REE is a survey of adults with serious mental illness designed to identify the extent to which recovery-enhancing factors are present within mental health programs and the extent to which individuals receiving services report that they are experiencing recovery.

Project Goals:
- To support a quality improvement process for CMHSPs and MDCH.
- To assist providers, consumers and other stakeholders develop a fundamental understanding of the elements of recovery.
- To strengthen recovery-oriented practices in individual service planning, systems planning and service delivery.
- To assess the extent to which recovery-enhancing elements are integrated into current practice for an unbiased, representative sample of programs and individuals.
- To provide summary data for use in developing plans to support and strengthen a recovery-based system of care.
- To provide summary data to MDCH and the Recovery Council to support policy development and technical guidance in the oversight of systems transformation.
- To provide baseline data to measure progress for future assessments.

Project Overview:
Each CMHSP will prepare a narrative plan describing how it will implement REE data collection and will complete the REE Table for the programs it operates. If the CMHSP contracts with outside agencies for programs, the REE Table will also be completed for each contract agency (detailed instructions follow).

These plans will be reviewed for completeness and feasibility by MDCH, and additions or corrections may be requested before the plan is approved. MDCH has contracted with Advocates for Human Potential (AHP) to assist the department and CMHSPs in implementing the REE. Two CMHSPs have volunteered to implement the survey in February 2009. MDCH will begin scheduling the remaining CMHSPs, first with "early adopter" volunteers, and the remainder as plans are approved and CMHSPs are ready to implement the survey.

Data will be collected from representative samples of adults with serious mental illness who have received certain services for 90 days or longer. Data collection will occur in phases according to a schedule to be developed in consultation with MDCH. Procedure codes identifying the services to be surveyed are listed in the REE Table. Data collection will be facilitated by consumer surveyors who will be trained by AHP. Surveyors will provide instructions, hand out surveys, answer questions from

[2] A revised short form of the REE, called the REE-MI, will be used in Michigan.

survey participants, read survey questions aloud if requested, and enter the data online (except where participants take the survey online). Consumer surveyors will be interviewed, selected and employed through the Michigan Recovery Center of Excellence (MRCE) as independent contractual staff. The MRCE will serve as the REE Logistics Coordinating agency (referred to later in this document).

Services for adults with serious mental illness included in REE implementation:

- Targeted case management
- Supports Coordination
- Assertive Community Treatment
- Psychosocial Rehabilitation
- Supported employment
- Consumer-run Drop Ins
- Medication clinics
- Group homes serving people diagnosed with serious mental illness
- People living in non-licensed housing who receive Community Living Supports

A maximum of $2000 in Federal Mental Health Block Grant Funding will be made available to support costs associated with transportation and refreshments for people who are not in a fixed program site so that they are supported to complete the survey at a group location. Please refer to "Instructions for Completing the Table and Plan Narrative Survey Methods" section C, page27.

CMHSP/Contract Agency Responsibilities:

Each CMHSP will provide MDCH and its contractors for this project with the name and contact information of an individual responsible for putting the approved REE Implementation Plan into practice within the CMHSP. This person's responsibilities will include:

- Contact each contract agency to explain REE implementation and get the name of a contact person responsible for REE logistics at each contract agency and program site to be surveyed.
- Ensure that each CMHSP program site has a contact person responsible for REE logistics.
- Facilitate the surveyor's work with each program site by providing them with all needed contact information, directions, introductions, other necessary information and computer access to enter survey data.
- Coordinate with contract agency and program site contacts to ensure that the approved sampling plan is carried out accurately in each program to be surveyed.
- Coordinate with contract agency and program site contacts to establish contact with the consumer surveyor(s) assigned to each program and have an initial planning and scheduling call or meeting with the surveyor(s).
- Ensure that the contract agency and program site contacts arrange for mutually-convenient times for the survey to be conducted in each program.
- Ensure that the contract agency and program site contacts are equipped to respond to questions or requests for clarification or assistance from surveyors.

- Coordinate with contract agency and program site contacts to arrange for appropriately-sized private space at each site for survey administration and access to a photocopier for the surveyor.

Consumer Surveyors:
To ensure that conflict of interest issues are addressed and that a trained surveyor group is assembled, MDCH and MRCE will handle the selection and assignment of surveyors. They will review applications of potential surveyors, hire surveyors, coordinate trainings to be provided by AHP, assign surveyors to programs, and reimburse surveyors for their time, and travel-related expenses. CMHSPs may recommend primary consumers to be surveyors.

Conflicts of Interest:
To ensure that there are no conflicts of interest between surveyors and CMHSPs or provider organizations, the following criteria will be strictly observed:

- Surveyors may not be current or former employees of the CMHSP or of the contract agency operating the program in which the survey is being administered.
- Surveyors may not administer the survey in programs run by organizations from which they currently or formerly received services.

Consumer Surveyors' Responsibilities:

- Keep AHP contact information readily available in the event that there is a need to ask questions regarding REE data collection or web-based data entry.
- Establish contact with the designated contact person responsible for implementing the REE at each program to which the surveyor is assigned.
- Hold an initial planning/scheduling call or meeting with the designated contact person to ensure that all parties are clear about when and where the surveyors will be responsible for conducting the survey.
- Keep all scheduled appointments to conduct the survey. If an emergency makes it impossible to keep a scheduled appointment, the designated contact person and the REE Logistics Coordinating agency must be contacted as soon as possible so that the appointment can be rescheduled or another surveyor assigned.
- Arrive at each scheduled site at least 20 minutes before the scheduled start time to ensure that the room is set up and needed supplies and/or equipment are set up.
- Bring sufficient pencils and paper copies of the survey to each site.
- Bring sufficient extra copies of the Recovery markers section of the survey so participants can make copies of that section to take with them.
- Contact the designated contact person and/or REE Logistics Coordinating agency if problems are encountered or questions during the survey process.
- Keep all completed paper surveys in a safe place before entering the data online, and return completed surveys to the REE Logistics Coordinating agency for secure storage in compliance with HIPAA rules and regulations.

Michigan REE Consumer Surveyor Position Requirements
Part-time surveyors who are current or former consumers of mental health services are sought to administer the Recovery Enhancing Environment-Michigan (REE-MI) instrument in each CMHSP throughout the state.

Surveyors will receive training about how to introduce and administer the REE, as well as a survey implementation manual from the MDCH contractor, AHP. A toll-free number to call for assistance will also be made available. Surveyors will introduce and administer the REE to consumers, typically in group settings in a pare/pencil format. The survey will also be available in an online version. Surveyors will be responsible for entering data online from pencil/paper surveys. A more detailed description of surveyor tasks is available in the document "Mutual Responsibilities of CMHC/Agency Contacts and Consumer Surveyors" and will be used for review and discussion as part of the surveyor selection process.

Required and demonstrated skills:

- Experience using the internet and ability to do accurate data entry on a computer.
- Speak comfortably before groups of consumers.
- Communicate clearly with consumer groups and individuals about the purposes for completing the survey, how the data will be used, confidentiality of data, and instructions for survey completion (training and script will be provided).
- Work effectively one-on-one with individuals who may have difficulty reading the survey, who have questions, or who request support in the survey process.
- Work collaboratively with the REE contact at each program to be surveyed.
- Able to keep scheduled appointments, maintain accurate records, and complete required paperwork.

Required Characteristics:

- Familiarity with and support of recovery concepts and principles. Must be a current or former consumer of mental health services: for example, surveyors may be peer support specialists, members or staff of Drop-In Centers or other consumer-run programs, independent contractors, and/or other current or former consumers. However, surveyors may not conduct surveys in programs or organizations where they work or receive services

Instructions for Completing the Table and Plan Narrative:

Each CMHSP will complete the REE Table and develop a narrative plan, to be approved by MDCH, for implementing the REE within the CMHSP and in its contract and provider agencies. If you have questions, please call 1-866-931-4817 to receive technical assistance from the MDCH contractor, AHP. Please indicate that you are calling about the "Michigan REE Survey Implementation Plan development."

TABLE:

1. In the REE Table, complete Part 1 by providing the name, address, telephone number and email address of the person who will be responsible for implementing the REE for the CMHSP.

If the CMHSP has contract agencies, Parts 2 and 3 of the REE Table must be completed separately for **each** contract agency.

2. In the REE Table, Part 3, identify all services from column 1 (as identified by the procedure codes provided in column 2) that are offered by your CMHSP or contract agency. Enter the name of each local program on the respective line in column 3. It is important that a unique local program name be entered in this column. Enter the name, phone number and email address of the contact site for each local program in column 4. If you do not provide services of the type shown on any line, please cross that line out.

3. For each program listed in column 3, attach a brief narrative description of how the survey will be administered. There are a number of considerations to be taken into account, depending on the nature of the service, which will determine the most efficient method for administering the REE. Several illustrative examples are presented below. Please choose the one most appropriate to the program and enter the corresponding letter code in column 5 of the REE Table.

   Survey methods:

   A. The preferred method is for the REE to be administered in person to the selected sample of program enrollees in a group. If there are sufficient computers available on-site for consumers to enter their own responses online after a group introduction to the instrument by the surveyor, this will be an acceptable method of data collection. Each program will be assigned a unique link to the survey. In other cases, the survey will be administered in a paper/pencil version, with the surveyor collecting the completed surveys and doing the data entry later. This method would work in programs where the entire sample is present at one time, such as Psychosocial Rehabilitation programs. Whenever feasible, this would involve selecting the sample as soon as people arrive at the program, and doing the group introduction and REE administration as soon as the entire sample is present. (See 4, below, for discussion of sampling methods.)

B. A variation of this method could be used in cases in which less than the entire sample is present at one time. For example, if people from one part of the county attend a Drop-in Center only on Monday, Wednesday and Friday, while people from another area attend only on Tuesday and Thursday, it would not be possible to get a representative sample by administering the survey only on a Monday. In such cases, half the sample would be chosen and administered the survey on Monday, and the other half would be chosen and administered the survey on Tuesday.

C. Another variation could be used for programs which do not have a fixed program site, such as supports provided in residential settings, ACT teams or supported employment programs. In this instance, the people in the sample would be identified and would be provided transportation to a central site for the survey to be administered.

D. In programs where people are at the program site only for brief appointments, such as medication clinics or targeted case management, the survey would be administered individually or to small groups of people while they are waiting for appointments or after they finish with their appointments. This method would require survey administrators to explain the instrument to individuals or small groups sequentially, and to remain onsite until they had administered surveys to the entire sample.

E. To facilitate access to survey participation in situations in which options A-D described above would be difficult or for individuals within the selected sample who would prefer a non-group administered survey, online access to the survey will be made available to consumers who were part of the selected sample in each program. The surveyor will give participants the survey link assigned to the program, along with written instructions. A trained surveyor will be available for questions through a toll-free number staffed by the MRCE.

F. In situations in which none of the suggested methods described above are feasible, please describe an alternate method for administering the survey. Please describe how you will ensure that those surveyed receive an adequate explanation of the survey process; how they will have questions answered; how data will be entered, and how confidentiality and accountability will be ensured.

4. For each service listed in the REE Table, Part 3, calculate the number of individuals that will serve as an unbiased representative survey sample for this program. This number can be calculated using a sampling methodology; three types of sampling methods are described below. If none of these methods is appropriate for the program, please describe an alternative sampling method that will result in the necessary sample size.

Examples of Sampling Methods: For each program, calculate the sample size using the appropriate sampling method. Enter the average weekly number served in column 6, and the size of the sample in column 7.

For programs serving five or fewer people weekly, the following rule will be used:

If a CMHSP or contract agency operates only one such program of any given type, the program will not be surveyed. However, if the CMHSP or contract agency operates two or more programs of the same type, each serving 5 or fewer people weekly, a sample may be constructed by inviting all these individuals to a central location to be surveyed (up to a maximum of 25 people). Each of these programs must be listed separately in column 3, and the survey method for these multi-program surveys should be described in the narrative plan.

a. For services with a fixed program site and 25 or fewer average weekly number served, the sample is everyone served during the sample week.

b. For services with a fixed program site and 26 or more average weekly number served, the sample is the first 25 served in the sample week. In order to ensure that the sample size is reached, people should be asked to participate in the order in which they arrive, until there are 25 positive responses.

c. For services without a fixed program site (i.e., ACT teams), sample the 25 or more clients living closest to the program site where the survey will be administered. In order to ensure that the sample size is reached, people should be asked to participate until there are 25 positive responses. If the program serves fewer than 25 individuals weekly, the sample is everyone served during the sample week.

d. Other (please describe in plan narrative).

5. Completion of Data Collection. When data collection is completed, each CMHSP and contract agency will be asked to complete a revised REE Table showing how the final sample was developed. During data collection, the number of persons who decline to complete the survey will also be tracked separately.

REE Table: PLAN FOR ADMINISTERING THE RECOVERY ENHANCING ENVIRONMENT MEASURE

Part 1. Responsibility for Administering the REE in the CMHSP

CMHSP name: _____

Name of person responsible for overseeing REE implementation: _____

Address_____

Telephone _____ Email _____

Part 2. Responsibility for Administering the REE in Contract Agencies

[Skip if CMHSP directly administers **all** its programs. Otherwise, complete Parts 2 and 3 for **each** contract agency.]
In addition, provide the name and contact information of an on-site contact person for each local program surveyed in Part 3, column 4.

Contract Agency name: _____

Name of person responsible for overseeing REE implementation: _____

Address_____

Telephone _____ Email _____

Part 3. Sampling Plan for Administering the REE in the CMHSP or Contract Agency

1. Service	2. Procedure code	3. Local program name	4. Local program contact person: name, phone, email	5. Survey Method	6. Avg. weekly number served	7. Sample size
Targeted case management	T1017					
Supports Coordination	T1016					
Assertive Community Treatment	H0039					

1. Service	2. Procedure code	3. Local program name	4. Local program contact person: name, phone, email	5. Survey Method	6. Avg. weekly number served	7. Sample size
Psychosocial Rehabilitation	H2030					
Supported employment	H2023					
Consumer-run Drop Ins	H0023					
Medication clinics	H2010 90862 H0034					
Community Living Supports in licensed general AFC or specialized residential setting	QI element 8.6 or 8.8 **And** receive H2015 or H2016					
Community Living Supports in supported independent living program or own home	H2015 or H2016 or H0043					
TOTAL to be surveyed						

PLAN NARRATIVE TO ACCOMPANY REE TABLE.

1. Describe how the survey will be administered in each service listed in Part 3, column 3. If it is necessary to vary from the sample survey methods described above for any program, please indicate below how the CMHSP proposes to assure a representative, unbiased sample of service participants.
2. Identify primary consumers in the CMHSP area who are interested and demonstrate the qualifications described on page 25.
3. Identify the number of surveys to be conducted at a central site, described in Item C on page 27. Mental health block grant funding will be made available to assist with these meetings. Total funding available will be dependent on the plan and discussion with MDCH.

IMPROVING ACCESS TO SELF-DETERMINATION

Self-determination embodies a set of concepts and values that individuals receiving services from the public health system have the right to define their lives and the public mental health system should support them to do so. Michigan's Self-Determination Policy and Practice Guideline provides guidance to PIHPs and CMHSPs so that participants in concert with their allies may be successfully guided and supported in achieving arrangements that support self-determination. In order to encourage and support increased opportunities for more individuals to choose a self-determination arrangement, the MDCH recently published the "Choice Voucher System Self-Determination Technical Advisory Version 2.0." The MDCH will continue to provide support and guidance. Information included in this section will be used to guide these technical assistance efforts.

1. In table #1 that describes some key steps that need to be taken by the CMHSP to implement arrangements that support self-determination pursuant to the Self-Determination Policy and Practice Guideline, indicate whether the CMHSP has taken the step (yes or no), and if not, enter the date for completing the step.

SD Table #1

Steps to support Self-determination The CMHSP:	Yes No	If no, date for completion
1. Develops and makes available a set of methods that provide opportunities for the consumer to control and direct their specialty mental health services and supports arrangements.		
2 Assures that full and complete information about self-determination and the manner in which it may be accessed and applied is provided each consumer.		
3 Provides a copy of the individual budget to the consumer prior to the onset of a self-determination arrangement.		
4 Makes an agreement in writing between the CMHSP and the consumer delineating the responsibility and the authority of both parties in the use of the individual budget.		
5. Includes with the agreement a copy of the consumer's plan and individual budget		
6. Provides the necessary directions and assistance to the consumer in writing when the agreement is finalized		
7. Files the individual budget, once authorized, with the consumer's approved plan of service.		
8. Assures that when a consumer makes adjustments in the application of funds in an individual budget, these shall occur within a framework described in an attachment to the consumer's self-determination agreement		

Steps to support Self-determination The CMHSP:	Yes No	If no, date for completion
9. Provides for a range of options up to, and including, the direct retention of consumer-preferred providers through purchase-of-services agreements between the consumer and the providers		
10. Makes clear to a consumer participating in self-determination that he/she is not obligated to utilize CMHSP-employed direct support personnel or a CMHSP-operated or –contracted program/service.		

2. In table #2 identify CMHSP staff designated as responsible for supporting Self Determination, and for ensuring that the Self Determination Policy and Practice Guideline is implemented:

SD Table #2

CMHSP staff	
Name	
Title	
Phone #	
E-mail address	

3. The CMHSP makes available qualified third-party entities that may function as fiscal intermediaries. In table # list the names of the fiscal intermediaries under contract with the CMHSP in FY 08 and the number of persons served by each fiscal intermediary in FY08.

SD Table #3

Name of Fiscal Intermediary [Add more rows as necessary]	# individuals served

4. The CMHSP has independent person-centered planning facilitators available within the service area. In table #4 provide the names of independent facilitators who provided this service in FY08 and number of plans facilitated.

SD Table #4

Name of Facilitator [Add more rows as necessary]	Number of individual plans facilitated in FY08

5. The CMHSP supports individuals with mental illness and developmental disabilities in self-determination arrangements in which the person controls the budget. In table #5 provide the number of people who controlled their own budgets in self-determination arrangements in FY 08.

SD Table #5

Adults who have control over their individual budget	# in FY08
Adults with mental illness with self determination arrangements with control over an individual budget.	
Adults with developmental disabilities with self determination arrangements with control over an individual budget.	

6. In Table #6 list the barriers that have slowed the progress of implementing self-determination and individual budgets for people served by the CMHSP.

SD Table #6

Barriers to Implementing Self-determination Arrangements & Individual Budgets

7. In table #7 list the technical assistance the CMHSP may need to increase opportunities for self-determination arrangements for the individuals it serves...

SD Table #7

Technical Assistance Needed

Technical Assistance Needed